6.0 OPERATIONS MANAGEMENT: AUTHORIZE SERVICES

6.1 Authorize personal Choice Waiver Service

6.1.1 MITA Business Process Model

- Operations Management: OM1 Authorize Service

6.1.2 Future Capability Overview

Within 5 years, all aspects of this process will be incorporated into the Mange Case business process in the Care Management business area. The authorizing of non-medical supplies or service from a client's Personal Choice Waiver budget will become managed within an integrated case management system, which will allow for non-medical requests to be properly reviewed and approved or denied more efficiently and effectively.

6.2 Authorize RI Medicaid Service

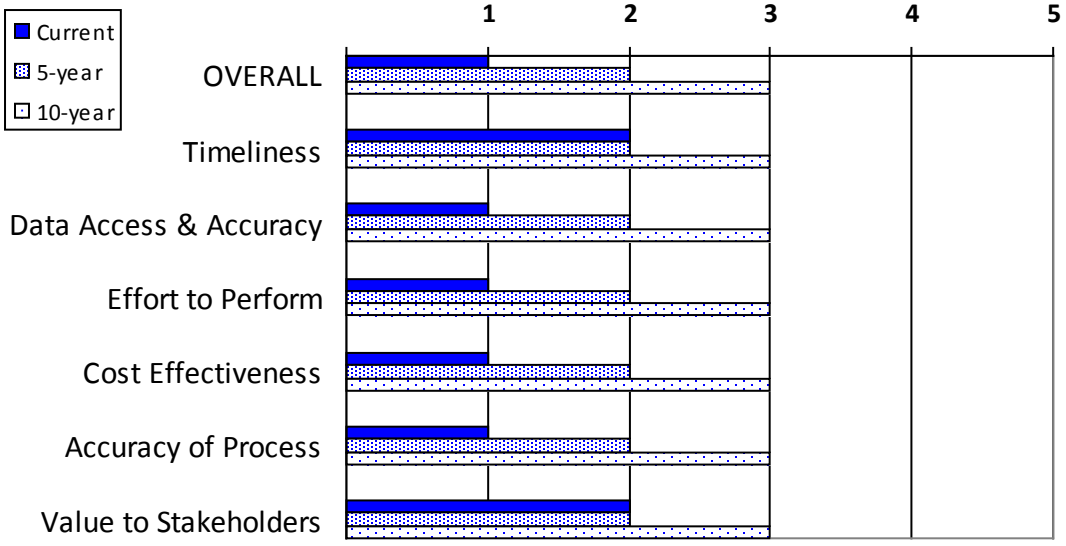
6.2.1 MITA Business process model

- Operations Management: OM1 Authorize Service

6.2.2 Future Capability Overview

As shown in the figure below, all aspects of the Authorize RI Medicaid Service business process will be at a capability level 2 in 5 years, with more timely processing, continued progression in use of electronic interchanges, and some automation of business rules. Within 10 years, all aspects of this process will be at a level 3, with flexible business rules and harmonization of the process across all programs with providers who treat medical assistance patients. Agencies will have electronic prior authorization submission and some automated processing in simple clinical decisions. Most qualities for this business process currently are at a level 1.

Figure 24: Current and Future Maturity Levels by Quality: Authorize RI Medicaid Service



6.2.3 Influences, Barriers and Facilitators

Among the many activities impacting the DHS, the following developments are expected to influence significantly the department's priorities related to reaching the 5- and 10-year capabilities for the Authorize RI Medicaid Services business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.[104]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this may include increased enrollment in managed care plans, which may result in a decreased number of beneficiaries whose care may be subject to the prior authorization process. However, greater attention to those with manageable conditions may require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the prior authorization process.[105]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.

[104] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[105] ibid

- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase prior authorization volume.
- HIPAA-compliance with implementing and utilizing the ASC X12N Health Care Services Review – Request for Review and Response (278) are consistent with improvement in the MITA capability levels.
- Increased availability of digital diagnostic information (e.g., lab results and radiology images) will decrease the amount of non-electronic data exchange required to support prior authorization business rules

6.2.4 Expected Characteristics

5-Year View

With increased automation and standardization improving authorization accuracy and timeliness, the Authorize RI Medicaid Service business process will be at a capability level 2 within 5 years.

Although not all authorizations will be automated and electronic (i.e., some manual, paper-based transactions will persist), manual and non-standard transactions will proportionately decrease over time. RI Medicaid will expand prior authorizations auto-adjudications through use of complex algorithms that evaluate authorization requests based on standardized business rules, which will result in greater consistency and accuracy. There also will be an increased use of electronic requests for additional information when required, some of which may be automated replies to the original electronic prior authorization request. Electronic interfaces will be HIPAA compliant.

This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for most qualities of the Medicaid prior authorization at Level 1. In addition, significant improvements to this process are not expected until after enhancements to the current MMIS are made, which is targeted after the 5-year view.

The table below summarizes the capability improvements for the Authorize RI Medicaid Service business process that are targeted over the next 5 years.

10-Year View

Integrated and automated authorization processes will use real-time, standardized data and business rules, which will support a level 3 capability for this business process within 10 years.

All siloed Medicaid authorization functions will be standardized and integrated. Although related behavioral health and elderly care processes may be supported by different systems and business rules, they will share common standards. Other agencies will benefit from sharing of the authorization data and the authorization business service (e.g., BHDDA, DEA).

The authorization processes will be completely automated with only rare occasions of manual review. Standardized data, web portals and authorization rules will be the main features of the shared process. Authorizations will be fully automated and optimized for real-time processing, which will further improve error rates and timeliness.

Business rules for authorization processing will be highly flexible so that changes can be made quickly and inexpensively. Because of these increased efficiency, staff can be redirected to more productive tasks (e.g., care management, program integrity).

The table below summarizes the capability improvements for the Authorize RI Medicaid Service business process that are targeted 5-10 years from now.

Table 24: Future Maturity Level by MITA Quality: Authorize RI Medicaid Service

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Increasing automation and standardization improves accuracy and timeliness.**	**2**	**Integrated and automated processes use real-time, standardized data and business rules.**	**3**
Timeliness	Improved process time due to increased use of automation. (No change from the Current View)	2	Optimizing automation will improve error rates and timeliness, thereby enabling support of real-time processing.	3
Data Access & Accuracy	Mix of paper / phone / fax / EDI HIPAA compliant interfaces.	2	Standardized data, web portals and authorization rules All siloed authorization processes will be integrated	3
Effort to Perform	Authorize Service process will generate electronic requests for additional information when applicable.	2	Authorize Service process will be completely automated with rare occasions of manual review.	3
Cost Effectiveness	Maintenance will continue to be expensive and time-consuming (no change from Current View)	2	Due to increased efficiency, staff can be redirected to more productive tasks	3
Accuracy of Process	Increasing use of complex algorithms to improve automation, consistency and correctness Despite progress, continued difficulty in making changes to business rules	2	Authorize Service processing will be highly flexible so that rule changes can be made quickly and inexpensively.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	Agencies will benefit from improved automation. (No change from the Current View)	2	Agencies will benefit from sharing of the business service and information with other agencies	3

6.3 Establish Care Plan

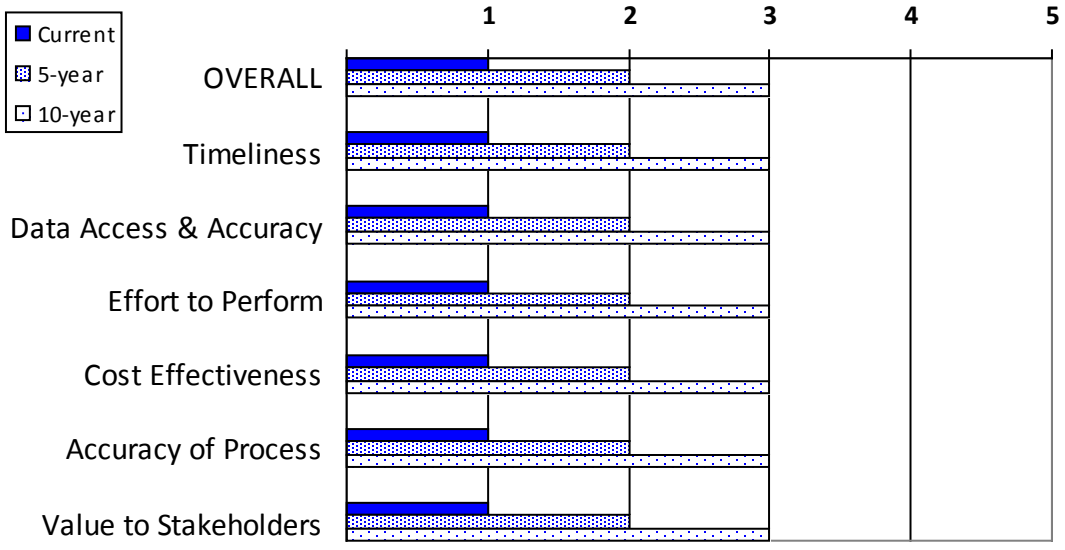
6.3.1 MITA Business process model

- Operations Management: OM1 Authorize Treatment Plan

6.3.2 Future Capability Overview

As shown in the figure below, all aspects of the Establish Care Plan business process will be at a capability level 2 in 5 years, with timelier processing, introduction of web portals and EDI, and some automation of business rules. Within 10 years, all aspects of this process will be at a level 3, with increased automation and standard interfaces. The Establish Care Plan processing is highly flexible so that rule changes can be made quickly and inexpensively. Most qualities for this business process currently are at a level 1.

Figure 25: Current and Future Maturity Levels by Quality: Establish Care Plan



6.3.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Office of Institutional and Community Services and Supports' priorities related to reaching the 5- and 10-year capabilities for the Establish Care Plan business process:

Strategic Planning Influences

- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[106]
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the care planning process.[107]
- As part of Community Living Initiative, HHS is working with several Federal agencies, including the Centers for Medicare & Medicaid Services (CMS), to implement solutions that address barriers to community living for individuals with disabilities and older Americans.

[106] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[107] ibid

- A goal of the Global Waiver is to ensure that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice.[108]
- A goal of the Global Waiver is to advance efficiencies through interdepartmental cooperation.[109]

Facilitators and Barriers

- A new CMS proposed rule makes it easier for states to provide home and community based services in the Medicaid program. More persons with disabilities who wish to live in the community and not in institutions would be able to do so under the proposed regulations. The proposed rule also clarifies what constitutes a true HCBS setting and sets out new requirements for "person-centered" care plans.
- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the case management-related components of this system and are critical to the efficient operation of this business process.
- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.[110]

[108] ibid
[109] ibid
[110] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.

6.3.4 Expected Characteristics

5-Year View

Enhancing the capabilities of the existing CSM application with increased automation and electronic exchange capabilities, or with the introduction of an integrated case management system the Establish Care Plan business process will be at a capability level 2 within 5 years.

Although there are improvements in automation for establishing a care plan, the care plan approval process may remain manual. There may be some automation of rules, but much of the review and coordination among entities and departments will remain somewhat labor intensive.

This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Establish Care Plan are at Level 1.

The table below summarizes the capability improvements for the Establish Care Plan business process that are targeted over the next 5 years.

10-Year View

Optimizing automation will improve errors and timeliness which will support a level 3 capability for this business process within 10 years. Interdepartmental collaboration will allow Medicaid case management business units to leverage a case manage tool across all programs.

During this period of time, all programs will be using semantically interoperable data in the process. Standardized data and care plan rules enable tracking of overutilization of similar services and appropriateness of medical services provided.

The table below summarizes the capability improvements for the Establish Care Plan business process that are targeted 5-10 years from now.

Table 25: Future Maturity Level by MITA Quality: Establish Care Plan

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Establish Care Plan request may be a mix of paper/phone/fax and EDI via X12 278 transaction or web portal.**	**2**	**Process will be standardized and will be automated using standard interfaces.**	**3**
Timeliness	Process time is faster than level 1 because of Web portal, EDI, or other automated form.	2	Optimizing automation improves error rates and timeliness, thereby enabling support of real-time processing.	3
Data Access & Accuracy	Establish Care Plan data continue to be submitted to siloed payment systems using state specific format and data, such as provider type and service codes. As a result, data continues to lack comparability across silos.	2	Web portals or EDI support error free submissions with data field masks, client-side edits, and pre-populated fields, thereby eliminating the need for these submissions to go through manual validation.	3
Effort to Perform	Establish Care Plan processes generate and electronic request for additional information via an X12 277 if additional information is required.	2	The Establish Care Plan process is completely automated and only rate exceptions must be manually reviewed.	3
Cost Effectiveness	Maintenance may still be expensive and time-consuming during this period.	2	Due to increased efficiency, staff can be redirected to more productive tasks.	3
Accuracy of Process	The increased centralization of business processes promotes harmonized rules across some silos.	2	Establish Care Plan processing is highly flexible so that rule changes can be made quickly and inexpensively in response to need for new or different rules.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	The Agency benefits from introduction of automation.	2	The Agency benefits from sharing of business service and information with other departments.	3

7.0 OPERATIONS MANAGEMENT: THIRD PARTY LIABILITY

7.1 Manage RI Medicaid Drug Rebate

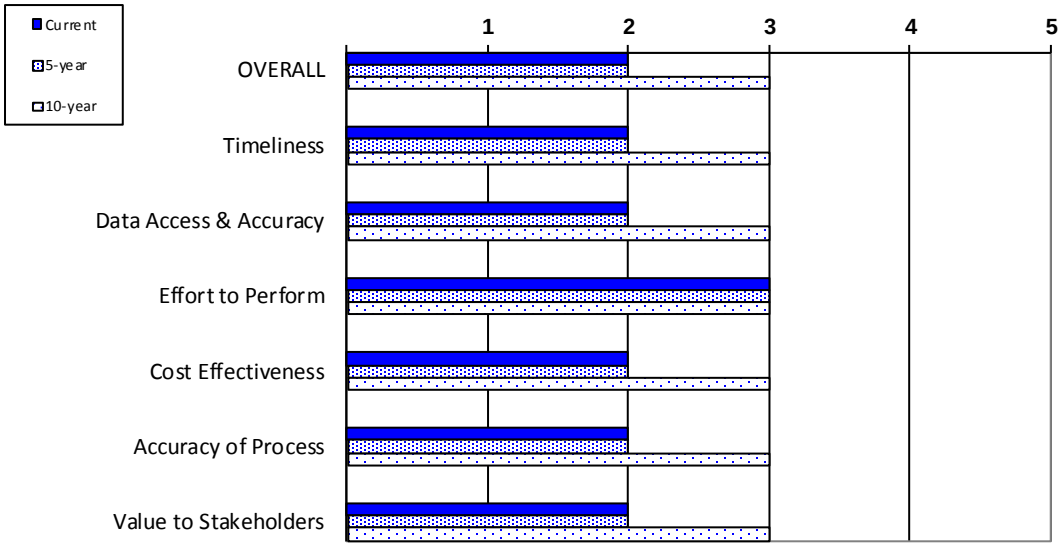
7.1.1 MITA Business process model

- Operations Management: OM7 Manage Drug Rebate

7.1.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Drug Rebate business process will remain at a capability level 2 in 5 years. There are no initiatives that will significantly impact the maturity of this process. Within 10 years, all aspects of this process will be at a level 3, with the use of standardized data and interfaces to exchange information intra-state and regionally. Most qualities for this business process currently are at a level 2.

Figure 26: Current and Future Maturity Levels by Quality: Manage RI Medicaid Drug Rebate



7.1.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Third Party Liability Unit's priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid Drug Rebate business process:

Strategic Planning Influences

- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this may include improved analysis of Medicaid service utilization data that could influence decisions related the Medicaid formulary based on their historical or expected effectiveness.[111]
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.[112]
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims.[113]
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan

[111] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[112] ibid
[113] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

market access and competition for the benefit of the Medicaid program and its managed care enrollees.[114]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase retail pharmacy volume.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[115]
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.[116]

7.1.4 Expected Characteristics

5-Year View

The Mange RI Medicaid Drug Rebate business process will remain at a capability level 2 within 5 years.

This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for most applicable qualities of the Manage RI Medicaid Drug

[114] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[115] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5
[116] Ibid, Slide 6

Rebate are at Level 2. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.

The table below summarizes the capability improvements for the Manage RI Drug Rebate business process that are targeted over the next 5 years.

10-Year View

Standardization of data and interfaces to exchange information intra-state and regionally will support a level 3 capability for this business process within 10 years.

Validation of rebate data will be totally automated with electronic data exchange for more consistent, timely and appropriate communications. All invoicing will be electronic to drug manufacturers.

The table below summarizes the capability improvements for the Manage RI Drug Rebate business process that are targeted 5-10 years from now.

Table 26: Future Maturity Level by MITA Quality: Manage RI Medicaid Drug Rebate

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**DHS will begin centralizing drug utilization data from siloed programs and automating validation processes.**	**2**	**The process will use standardized data and interfaces to exchange information intra-state and regionally.**	**3**
Timeliness	Process time will speed up due to automation. (No change from the Current View)	2	Communications will be more consistent, timely and appropriate.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Data Access & Accuracy	Data will be standardized for automated electronic interchanges (interfaces) between agencies and drug manufacturers. (No change from the Current View)	3	Data will be standardized for automated electronic interchanges (interfaces) between agencies and drug manufacturers. (No change from the 5-year View)	3
Effort to Perform	Validation will be mostly automated. (No change from the Current View)	2	Validation will be fully automated.	3
Cost Effectiveness	Increased data accuracy and completeness will create more cost-effectiveness. (No change from the Current View)	2	Agencies will adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally.	3
Accuracy of Process	More consistency in rule creation and application. (No change from the Current View)	2	Rules will be consistently applied.	3
Value to Stakeholders	Cost management programs will be implemented that bring value to stakeholders. (No change from the Current View)	2	Focus will be on Member, Provider, and Medicaid Operations business services.	3

7.2 Manage RI Medicaid Estate Recovery

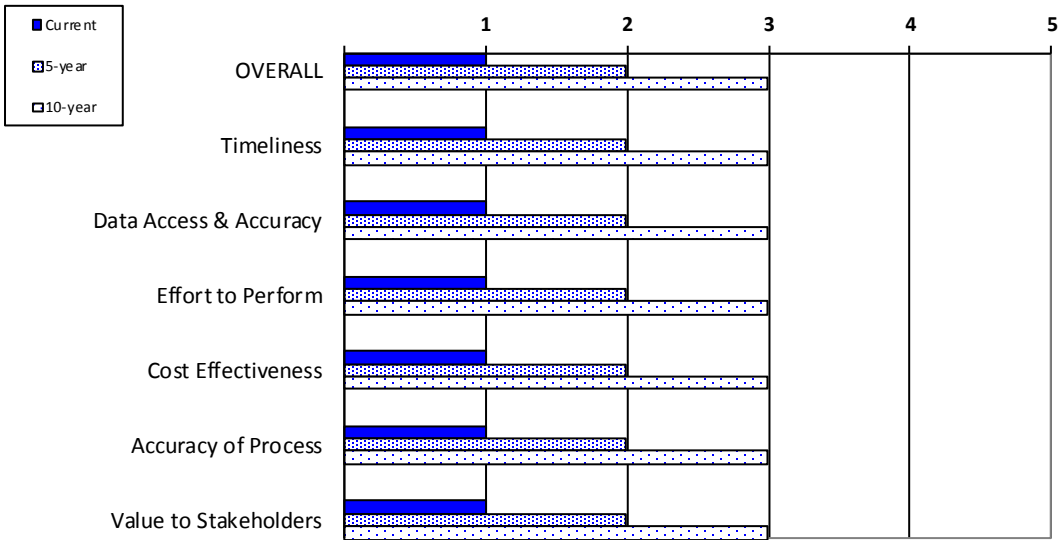
7.2.1 MITA Business process model

- Operations Management: OM7 Manage Estate Recovery

7.2.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Estate Recovery business process will be at a capability level 2 in 5 years, with the introduction of standardization and increased automation of the business process. Within 10 years, all aspects of this process will be at a level 3, with improved standardization and full automation of the business process. All qualities for this business process currently are at a level 1.

Figure 27: Current and Future Maturity Levels by Quality: Manage RI Medicaid Estate Recovery



7.2.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Third Party Liability Unit's priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid Estate Recovery business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to file a lien against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid.[117]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[118]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or

[117] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[118] ibid

just a new Medical Assistance system specifically for Medicaid. Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management functions.

- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the volume of estate recoveries for those in long-term care setting.

7.2.4 Expected Characteristics

5-Year View

With the introduction of standardization and some automation, the Manage RI Medicaid Estate Recovery business process will be at a capability level 2 within 5 years.

This process uses electronic interchange and automated processes, for example, receiving data from Community Service Offices, date of death matches, probate petition notices and reports of death from nursing homes which increases coordination and improves timeliness, consistency, and access for stakeholders involved in the process.

This business process is not expected to reach a level 3 within 5 years. Current initiatives will only advance maturity to a level 2. All capabilities for this business process are currently as a level 1.

The table below summarizes the capability improvements for the Manage RI Medicaid Estate Recovery business process that are targeted over the next 5 years.

10-Year View

With standardization and almost full automation, the Manage RI Medicaid Estate Recovery business process will be at a capability level 3 within 10 years.

Communications to stakeholders and member's personal representatives will be consistent, timely, and appropriate. Process will have almost eliminated its use of non-electronic interchange and will have automated most processes.

Improved claims payment turnaround and increased electronic claims submission will increase the timeliness of recoveries. Availability of online national death records and regional exchange of probate data with other states will be possible with national standards, shared business services, and common interfaces.

The table below summarizes the capability improvements for the Manage RI Medicaid Estate Recovery business process that are targeted 5-10 years from now.

Table 27: Future Maturity Level by MITA Quality: Manage RI Medicaid Estate Recovery

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Processes will be mostly automated using standard interfaces.**	**2**	**Process will be fully automated using standard interfaces.**	**3**
Timeliness	Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.	2	Communications to stakeholders and member's personal representatives will be consistent, timely, and appropriate.	3
Data Access & Accuracy	Agencies are standardizing data to increase coordination and consistency, therefore enhancing usefulness for determining the value of estate liens and improving the timeliness and accuracy of the case follow-up, ensuring recovery is	2	Process will have almost eliminated its use of non-electronic interchange and will have automated most processes	3
Effort to Perform	Validation is mostly automated.	2	Validation will be fully automated.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Cost Effectiveness	Increased data accuracy and completeness creates more cost-effectiveness.	2	Agencies will adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally.	3
Accuracy of Process	Increased data accuracy and completeness creates more cost-effectiveness.	2	Rules will be consistently applied. Decisions will be uniform.	3
Value to Stakeholders	Cost management programs are implemented that bring value to stakeholders.	2	Focus will be on Member, Provider, and Medicaid Operations business services. Stakeholders will experience increased satisfaction in the way their needs are met.	3

7.3 Manage RI Medicaid Recoupment

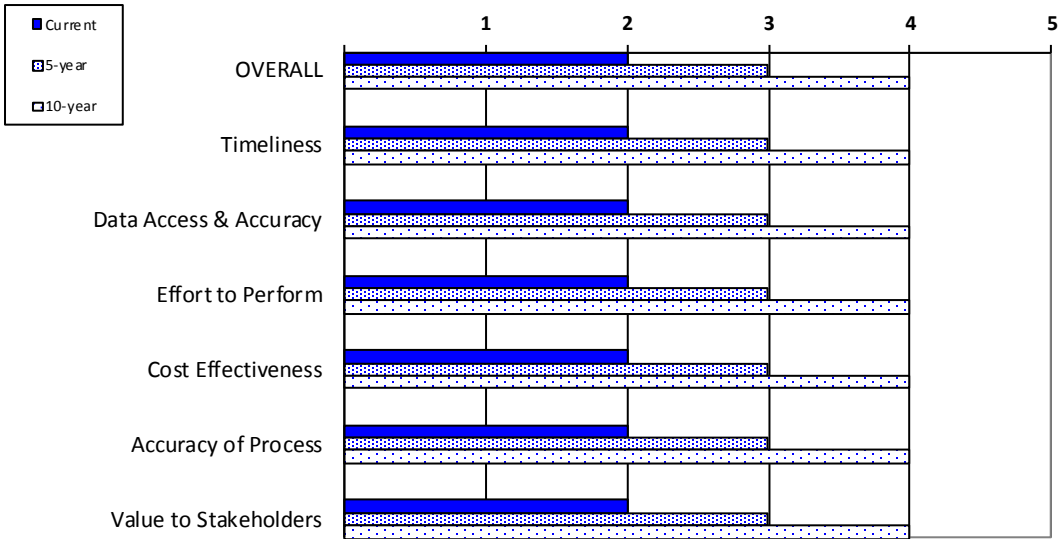
7.3.1 MITA Business Process Model

- Operations Management: OM7 Manage Recoupment

7.3.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Recoupment business process will be at a capability level 3 in 5 years, with almost complete automation with improved data exchange. Within 10 years, all aspects of this process will be at a level 4, with immediate processing via federated architectures. All qualities for this business process currently are at a level 2.

Figure 28: Current and Future Maturity Levels by Quality: Manage RI Medicaid Recoupment



7.3.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Third Party Liability Unit's priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid Recoupment business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to recover the costs of Medicaid benefits incorrectly paid as primary payer during the time the member was eligible for Medicaid.[119]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[120]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.

[119] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[120] ibid

- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or just a new Medical Assistance system specifically for Medicaid. Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the volume of estate recoveries for those in long-term care setting.

7.3.4 Expected Characteristics

5-Year View

With almost complete automation with more application to application communications, the Manage RI Medicaid Recoupment business process will be at a capability level 3 within 5 years.

Communications to providers as well as members will be consistent, timely and appropriate. The business process will have almost eliminated its use of non-electronic interchange, with fully automated recovery notifications and immediate validation of recoverable claims. Referral data resulting from the claims adjudication process will be reflected real-time within the TPL subsystem. Due to increased efficiency, staff can be redirected to more productive tasks, e.g., improving performance of recovery operations.

The table below summarizes the capability improvements for the Manage RI Medicaid Recoupment business process that are targeted over the next 5 years.

10-Year View

Immediate processing and interfaces with other processes via federated architectures will support a level 4 capability for this business process within 10 years.

Process time will be immediate for all overpayment "referrals" with the use of clinical data in real time. Data from other Operations Management business processes (i.e., Edit Claim) will immediately trigger messages to the Manage RI Medicaid Recoupment business process. Claims payment data will be retrieved immediately and claim will be readjudicated to reflect the recoverable claims; alternately, electronic recovery notices will be sent to the provider. Greater efficiencies will allow additional redirected staff to improve program performance outcomes, care management, or further maximize recoveries.

The table below summarizes the capability improvements for the Manage RI Medicaid Recoupment business process that are targeted 5-10 years from now.

Table 28: Future Maturity Level by MITA Quality: Manage RI Medicaid Recoupment

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Process will be almost completely automated with improved application-to- application communications.**	**3**	**Process will be immediate and interface with other processes via federated architectures.**	**4**
Timeliness	Communications to providers will be consistent, timely and appropriate	3	Process time will be immediate. Clinical data is available in real time.	4
Data Access & Accuracy	Process will have almost eliminated its use of non-electronic interchange and has automated most processes More application-to-application communications	3	Process will interface with other processes via federated architectures	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Effort to Perform	Validation will be fully automated and immediate	3	Data will trigger registry updates and push data to other applications	4
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction	4
Accuracy of Process	Consistency and predictability of the process.	3	Use of clinical data will improve consistency of results.	4
Value to Stakeholders	Agencies will benefit from sharing of the business service and information with other agencies.	3	Providers, members, and care managers will access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	4

7.4 Manage Hospital Cost Settlements

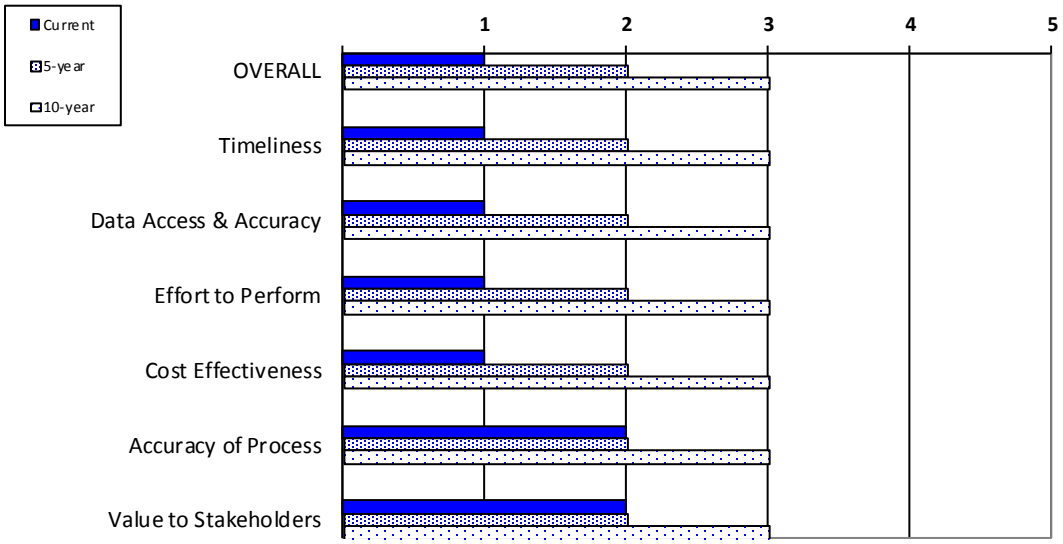
7.4.1 MITA Business Process Model

- Operations Management: OM7 Manage Settlements

7.4.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage Hospital Cost Settlements business process will be at a capability level 2 in 5 years, with increased automation and electronic data exchanges. Within 10 years, all aspects of this process will be at a level 3, with almost complete automation and improved timeliness of reporting. Qualities for this business process are currently at a level 1 or 2.

Figure 29: Current and Future Maturity Levels by Quality: Manage Hospital Cost Settlements



7.4.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Rate Setting Unit's priorities related to reaching the 5- and 10-year capabilities for the Manage Hospital Cost Settlements business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to review provider costs and establish a basis for cost settlements or compliance reviews.[121]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[122]
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create mechanisms that support the Department's goal of rewarding improved plan performance.[123]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the

[121] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[122] ibid
[123] ibid

authorization-related components of this system and are critical to the efficient operation of this business process.

- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.[124]

7.4.4 Expected Characteristics

5-Year View

With centralization of the process and increased automation, the Manage Hospital Cost Settlements business process will be at a capability level 2 within 5 years.

Information will be received in an automated, timely manner. DHS will begin aligning similar processes across the Department. MMIS data will be readily available to the business process and will improve accuracy and cost effectiveness.

This RI Medicaid business process is not expected to be at Level 3 within 5 years. Most qualities are currently at a Level 1. Any significant improvements to this process are not expected until after enhancements to the MMIS, which is targeted for the latter half of the 5-year view.

The table below summarizes the capability improvements for the Manage Hospital Cost Settlements business process that are targeted over the next 5 years.

10-Year View

Almost complete automation with more application to application communications will support a level 3 capability for this business process within 10 years.

The process will be standardized across DHS programs and almost completely automated. The Rate Setting Unit will utilize standardized interfaces and data to perform the Manage Hospital Cost Settlement business process. Process time can be immediate using an automated validation process for incoming data.

[124] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 6

The table below summarizes the capability improvements for the Manage Hospital Cost Settlements business process that are targeted 5-10 years from now.

Table 29: Future Maturity Level by MITA Quality: Manage Hospital Cost Settlements

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**The process will become centralized and will increase use of automation and electronic interchanges.**	**2**	**Process will be standardized and almost fully automated.**	**3**
Timeliness	Process time will be faster than level 1 because of Web portal, EDI, or other automated form.	2	Process can be immediate.	3
Data Access & Accuracy	Increasing use of electronic interchange and automated processes.	2	Process will have almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	3
Effort to Perform	Validation will be mostly automated.	2	Validation will be fully automated.	3
Cost Effectiveness	Increased data accuracy and completeness will create more cost-effectiveness.	2	Due to increased efficiency, staff can be redirected to more productive tasks	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Accuracy of Process	More consistency in program rule application. (No change from the Current View)	2	Rules will be consistently applied.	3
Value to Stakeholders	Cost management programs will be implemented that bring value to stakeholders. (No change from the Current View)	2	Focus will be on Member, Provider, and Medicaid Operations business services. Stakeholders will experience increased satisfaction in the way their needs are met.	3

7.5 Manage RI Medicaid TPL Recovery

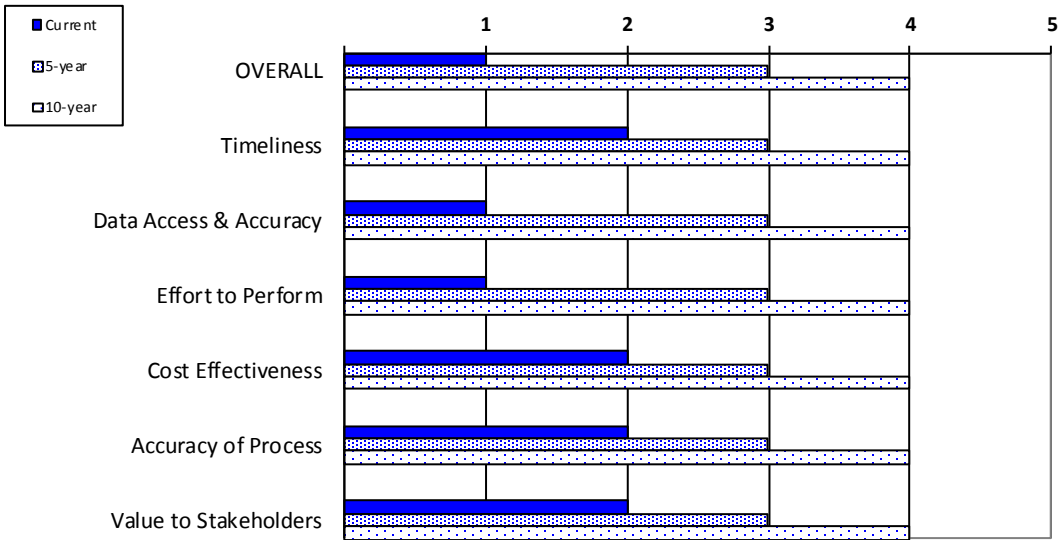
7.5.1 MITA Business Process Model

- Operations Management: OM7 Manage TPL Recovery

7.5.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid TPL Recovery business process will be at a capability level 3 in 5 years, with real-time electronic information exchanged between agency and third-party payment recovery partners. Within 10 years, all aspects of this process will be at a level 4, with immediate processing and use of local RHIOs for COB coordination. Qualities for this business process currently are at a level 1 or 2

Figure 30: Current and Future Maturity Levels by Quality: Manage RI Medicaid TPL Recovery



7.5.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Third Party Liability Unit's priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid TPL Recovery business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to recover the costs of Medicaid benefits incorrectly paid as primary payer during the time the member was eligible for Medicaid.[125]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[126]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.

[125] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[126] ibid

- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or just a new Medical Assistance system specifically for Medicaid. Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the volume of estate recoveries for those in long-term care setting.

7.5.4 Expected Characteristics

5-Year View

With standardization of data exchanges and increased use of payer-to-payer interfaces, the Manage RI Medicaid TPL Recovery business process will be at a capability level 3 within 5 years.

Communications throughout the business process with other payers will be consistent, timely, and appropriate. Requests and responses will be automated and standardized among the Department's TPL data sharing partners. The process will exchange data with an increased number of data sources outside the department (e.g. DMV) for potential identification of additional responsible payers. Due to increased efficiency, staff can be redirected to more productive tasks (e.g., recoveries, case-finding).

The table below summarizes the capability improvements for the Manage RI Medicaid TPL Recovery business process that are targeted over the next 5 years.

10-Year View

Immediate processing and use of local RHIOs for COB coordination will support a level 4 capability for this business process within 10 years.

Response and payment will be accomplished immediately from third party payers, which will reduce the volume of TPL claims to be recovered. The business process will shift to automatic COB through local RHIOs for cost-avoidance versus cost recovery.

Receipt of electronic TPL data from various sources will automatically trigger the Manage RI Medicaid TPL Recovery business process. Data will be automatically validated, recoverable claims will be automatically retrieved, and notification will be sent to the provider or TPL carrier. Full automation of the process plus access to clinical data for case-finding will refocus staff increasingly on improving TPL Unit performance outcomes and identifying opportunities for care management

The table below summarizes the capability improvements for the Manage RI Medicaid TPL Recovery business process that are targeted 5-10 years from now.

Table 30: Future Maturity Level by MITA Quality: Manage RI TPL Recovery

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Process will be standardized and use payer-to-payer COB interfaces.**	**3**	**Process will be immediate and COB will automatically process through local RHIOs.**	**4**
Timeliness	Communications will be consistent, timely, and appropriate	3	Response and payment outcomes are immediate.	4
Data Access & Accuracy	Process will use standard interfaces for payer–to payer COB process.	3	COB will be automatically coordinated through the local RHIO registry.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Effort to Perform	Business services will standardize requests and responses nationally.	3	Data will trigger registry updates and push data to other applications	4
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction	4
Accuracy of Process	Rules will be consistently applied.	3	Incorporation of clinical data will improve accuracy of some responses.	4
Value to Stakeholders	Agencies will benefit from sharing of the business service and information with other agencies.	3	Providers, members, and care managers will access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	4

8.0 OPERATIONS MANAGEMENT: CLAIMS PROCESSING

8.1 Apply RI Medicaid Claim Attachment

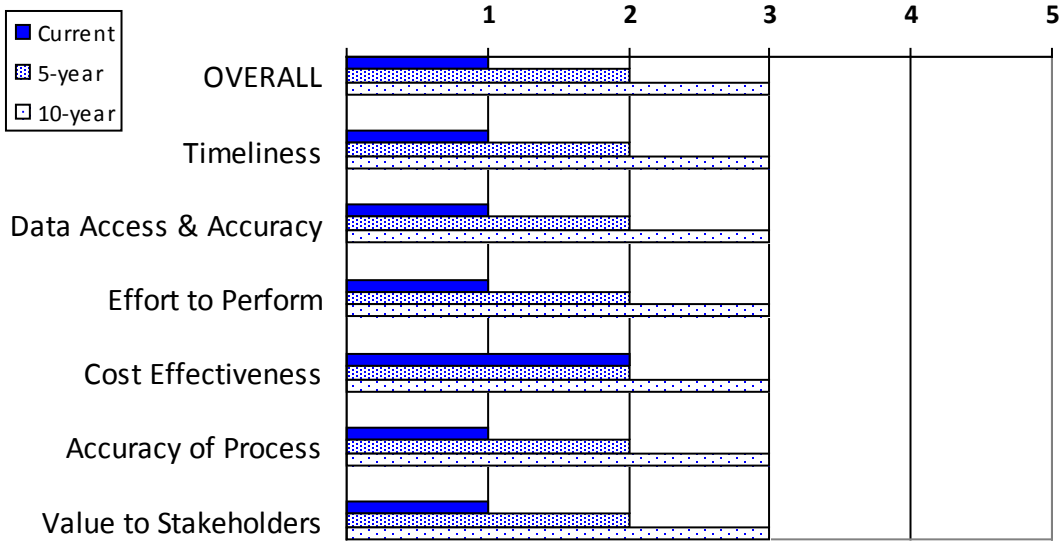
8.1.1 MITA Business process model

- Operations Management: OM2 Apply Claim Attachment

8.1.2 Future Capability Overview

As shown in the figure below, all aspects of the Apply RI Medicaid Claim Attachment business process will be at a capability level 2 in 5 years, with increased use of electronic attachments. Within 10 years, all aspects of this process will be at a level 3, with use of national standards for claim attachments and almost full automation. Most qualities for this business process currently are at a level 1.

Figure 31: Current and Future Maturity Levels by Quality: Apply RI Medicaid Claim Attachment



8.1.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Apply RI Medicaid Claim Attachment business process:

Strategic Planning Influences

- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims.[127]
- The Affordable Care Act calls for the establishment of an Interim Final Rule for Standards and Operating Rules for health Claims Attachments not later than January 1, 2014. Compliance with this federal mandate will facilitate maturity in this business process.[128]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.
- Increased availability of digital diagnostic information (e.g., lab results and radiology images) will decrease the amount of non-electronic data exchange required to claims processing business rules.

[127] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[128] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1104(c)(3)

- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.

8.1.4 Expected Characteristics

5-Year View

With increased use of electronic attachments, the Apply RI Medicaid Claim Attachment business process will be at a capability level 2 within 5 years.

Although not all attachments will be electronic (i.e., some manual, paper-based transactions will persist), manual and non-standard transactions will proportionately decrease over time. Medical providers will increasingly submit claims and attachments electronically. With the increase in electronic attachments for medical claims processing, staff can be refocused to other strategic duties.

This Medicaid business process is not expected to be at Level 3 within 5 years. Most capability qualities for this business process are currently at a Level 1. Significant improvements to this process are not expected until after the enhancements to the existing MMIS, which are targeted for later in this first 5-year view.

The table below summarizes the capability improvements for the Apply RI Medicaid Claim Attachment business process that are targeted over the next 5 years.

10-Year View

With use of national standards for claim attachments and almost full automation, the Apply RI Medicaid Claim Attachment will be at a level 3 capability within 10 years.

The claim attachment processes will be completely automated with only rare occasions of paper submission. Standardized data, web portals and claim attachment rules will be the main features of the shared process. Claim attachments will be fully automated using national standards and optimized for real-time processing, which will further improve error rates and timeliness. Field offices will begin to access

clinical records (hospital records) to support claims processing in real-time, reducing the need for an attachment.

Interdepartmental collaboration will allow Medicaid programs to leverage MMIS improvements across the various claim types. Although the process for other programs may be supported by different systems with different business rules, they will share common standards. Other department will benefit from sharing of the Medicaid data for this business process.

The table below summarizes the capability improvements for the Apply RI Medicaid Claim Attachment business process that are targeted 5-10 years from now.

Table 31: Future Maturity Level by MITA Quality: Apply RI Medicaid Claim Attachment

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Increased use of electronic attachments will create a more efficient process.**	**2**	**Use of national standards increases speed and accuracy of processing. The majority of attachments are submitted electronically.**	**3**
Timeliness	Electronic attachments will shorten time required to match with claim and edit	2	Use of national standards for claims attachments increases speed	3
Data Access & Accuracy	A mix of paper and electronic attachments.	2	Only a small number of providers submit paper attachments.	3
Effort to Perform	Electronic attachments will refocus staff on other business functions	2	Use of national standards for the Claim Attachment facilitates performance.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Cost Effectiveness	Cost effectiveness will increase through implementation of programs that target management of costs. (No change from current view)	2	Agencies adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally.	3
Accuracy of Process	Accuracy will improve.	2	Accuracy will continue to improve	3
Value to Stakeholders	Cost management programs will be implemented that bring value to stakeholder.	2	Stakeholders will experience increased satisfaction in the way their needs are met.	3

8.2 Apply Void and Replace

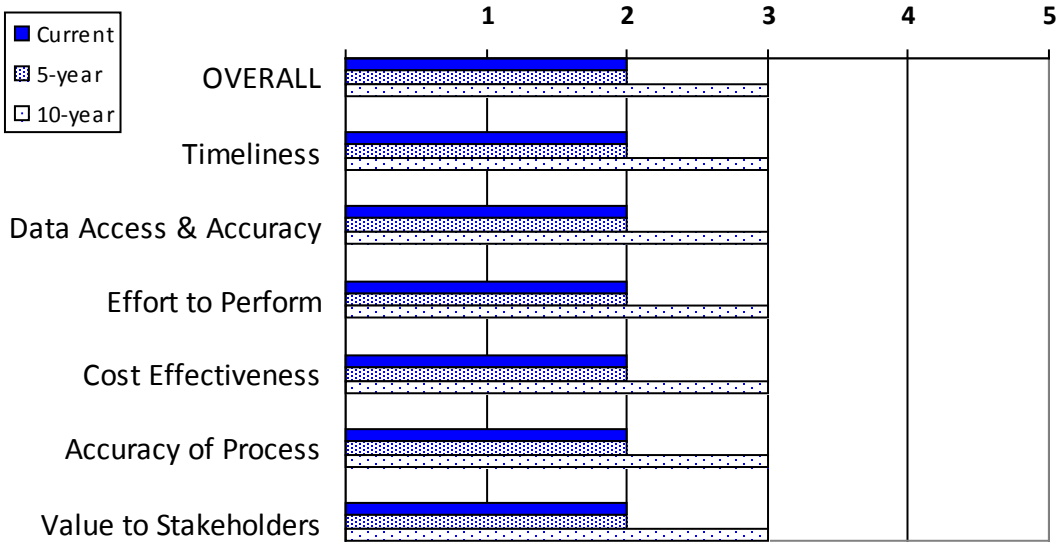
8.2.1 MITA Business process model

- Operations Management: OM2 Apply Mass Adjustment

8.2.2 Future Capability Overview

As shown in the figure below, all aspects of the Apply Void and Replace business process remain unchanged in 5 years, with no major initiatives currently underway that are expected to significantly impact the maturity of this process. Within 10 years, all aspects of this process will be at a level 3, as the Apply Void and Replace process will utilize MITA standards for its interfaces and for processing and will have the flexibility to easily change the criteria for identification of claims and application of the adjustment. All qualities for this business process currently are at a level 2.

Figure 32: Current and Future Maturity Levels by Quality: Apply Void and Replace



8.2.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence the Claims Unit's priorities related to reaching the 10-year capabilities for the Apply Void and Replace business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization and payments.[129]
- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[130]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

[129] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[130] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

8.2.4 Expected Characteristics

5-Year View

The Apply Void and Replace business process will remain at a capability level 2 within 5 years.

This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all applicable qualities of the Apply Void and Replace are at Level 2. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.

The table below summarizes the capability improvements for the Apply Void and Replace business process that are targeted over the next 5 years.

10-Year View

With data sharing standards and standard interfaces for void and replace, or mass adjustments to support immediate processing time, the process is immediate and supports a level 3 capability for this business process within 10 years.

Standardized data, web portals and mass adjustment rules will be the main features of the shared process. Mass adjustments will be fully automated and optimized for real-time processing which will improve accuracy and timeliness. The mass adjustment process will decrease due to improvements in other operations management business processes slated in 10 years. Due to improved efficiency, staff can be redirected to other operational and strategic activities.

Interdepartmental collaboration will allow Medicaid programs to leverage MMIS improvements across the various claim types. Although the process for other programs may be supported by different systems with different business rules, they will share common standards. Other agencies will benefit from sharing of the Medicaid service for this business process.

The table below summarizes the capability improvements for the Apply Void and Replace business process that are targeted 5-10 years from now.

Table 32: Future Maturity Level by MITA Quality: Apply Void and Replace

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**All qualities will remain at level 2 with the exception that with overall Medicaid program improvements, mass adjustments will decrease. (No change from current view)**	**2**	**Data sharing standards and standard interfaces for mass adjustments will be used.**	**3**
Timeliness	Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. (No change from current view)	2	Process time will be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange will improve timeliness.	3
Data Access & Accuracy	Identification of claims to be adjusted and application of the adjustment are automated with audit trail. (No change from current view)	2	Standard interfaces for mass adjustments will be used by the state Medicaid agency Data and format will be standardized via standard interfaces and include clinical data	3
Effort to Perform	Improvements throughout the Medicaid program operations will reduce the number of mass adjustments required. (No change from current view)	2	Effort to perform will be reduced and efficiency will be increased through state and regional data exchange, collaboration, adoption of data standards.	3
Cost Effectiveness	Less staff required to perform business process. Automation leads to fewer staff. (No change from current view)	2	Due to increased efficiency, staff can be redirected to more productive tasks.	3
Accuracy of Process	More consistency in rule creation and application. (No change from current view)	2	Rules will be consistently applied.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	The agency benefits from introduction of automation. (No change from current view)	2	Agencies will benefit from sharing of the business service and information with other agencies.	3

8.3 Calculate Medical Needy Spend-Down Amount

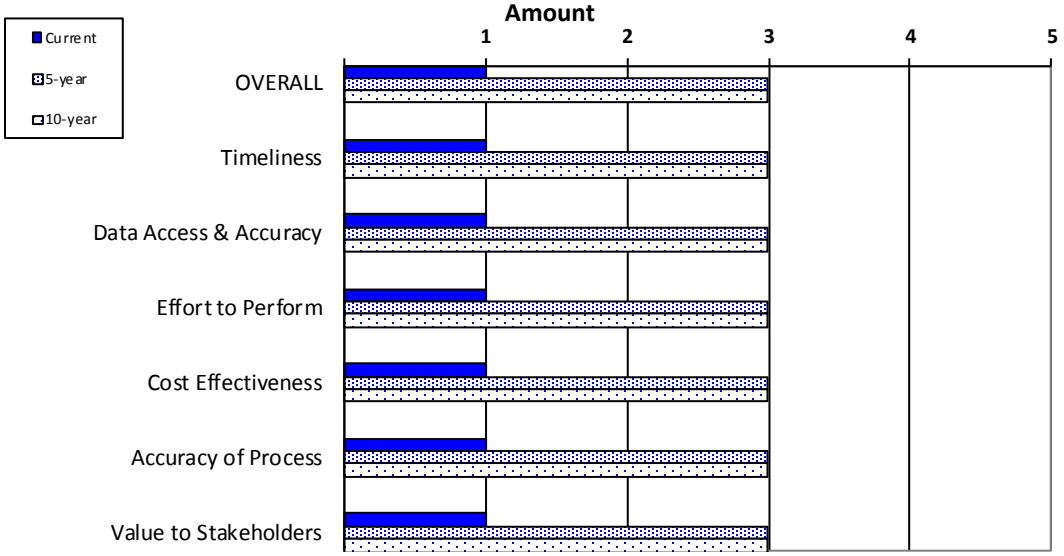
8.3.1 MITA Business process model

- Operations Management: OM6 Calculate Spend-Down Amount

8.3.2 Future Capability Overview

As shown in the figure below, all aspects of the Calculate Medial Needy Spend-Down Amount business process will be at a level 3 capability, were the member's account accumulator automatically accounts for excess resources during claims processing by debiting the amount paid by the member. Within 10 years, all aspects of this process will remain at a level 3. There are no initiatives that will significantly impact the capabilities of this process within 5- 10 years, unless the 5 year goal is not obtained. All qualities for this business process currently are at a level 1.

Figure 33: Current and Future Maturity Levels by Quality: Calculate Medical Needy Spend-Down Amount



8.3.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Calculate Medical Needy Spend-Down Amount business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively members financially responsible prior to Medicaid payment for any medical services.[131]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[132]
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims.[133]

[131] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[132] ibid
[133] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the need to determine a member's financial responsibility more effectively and efficiently.
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.[134]

8.3.4 Expected Characteristics

5-Year View

Elimination of the Spend-Down process due to immediate calculation during eligibility verification processing will support a level 3 capability for this business process within 5 years.

Deductible is automatically tracked within MMIS until threshold is met. System notifies staff and/or claims payment system when threshold is met. The Switch to auto-deductible accounting supports real-time reporting of spend-down totals.

The table below summarizes the capability improvements for the Calculate Medical Needy Spend-Down Amount business process that are targeted within 5 years from now.

[134] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

10-Year View

Within 5 - 10 years, the Calculate Medical Needy Spend-Down Amount will remain at a capability level 3. There are no initiatives within 5-10 years that will significantly impact the capability of this process, unless the 5 year goal is not obtained.

The table below summarizes the capabilities for the Calculate Medical Needy Spend-Down Amount business process for5-10 years from now.

Table 33: Future Maturity Level by MITA Quality: Calculate Medical Needy Spend-Down Amount

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	A separate Spend-Down process essentially is eliminated and is incorporated into the eligibility verification process.	3	A separate Spend-Down process essentially is eliminated and is incorporated into the eligibility verification process. (No change from 5- year View)	3
Timeliness	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange will improve timeliness	3	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange will improve timeliness (No change from 5- year View)	3
Data Access & Accuracy	The Calculate Spend-down Amount business process does not require that members report their costs.	3	The Calculate Spend-down Amount business process does not require that members report their costs. (No change from 5- year View)	3
Effort to Perform	Member's account will be debited by the amount paid by the member.	3	Member's account will be debited by the amount paid by the member. (No change from 5- year View)	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks.	3	Due to increased efficiency, staff can be redirected to more productive tasks. (No change from 5- year View)	3
Accuracy of Process	Claims are denied for billing to the member until spend down is met.	3	Claims are denied for billing to the member until spend down is met. (No change from 5- year View)	3
Value to Stakeholders	From the perspective of providers and members, other than billing the member, there will be no difference between spend down and the processing of other Medicaid claims.	3	From the perspective of providers and members, other than billing the member, there will be no difference between spend down and the processing of other Medicaid claims. (No change from 5-year View)	3

8.4 Edit and Audit RI Medicaid Claim:

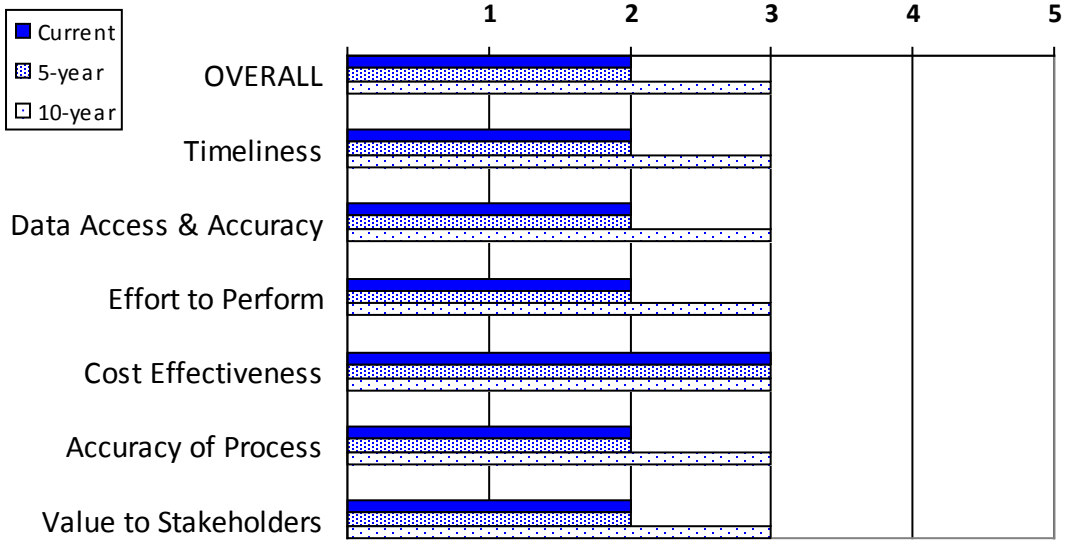
8.4.1 MITA Business process model

- Operations Management: OM2 Edit and Audit Claim/Encounter

8.4.2 Future Capability Overview

As shown in the figure below, most aspects of the Edit and Audit RI Medicaid Claim business process will remain at a capability level 2 in 5 years, with most providers submitting HIPAA compliant transactions. Within 10 years, all aspects of this process will be at a level 3, with use of standard interfaces and nearly full automation including payer-to-payer COB processing. At that time, the process will feature flexible business rules and harmonization across all programs that pay Medicaid claims, leveraging and adapting sharable Medicaid claims processing services to further align currently divergent processes. Most qualities for this business process currently are at a level 2.

Figure 34: Current and Future Maturity Levels by Quality: Edit and Audit RI Medicaid Claim



8.4.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence the Claims Unit's priorities related to reaching the 10-year capabilities for the Edit and Audit RI Medicaid Claim business process:

Strategic Planning Influences

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[135]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

8.4.4 Expected Characteristics

5-Year View

The Edit and Audit RI Medicaid Claim business process will remain at a capability level 2 within 5 years.

This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for most qualities of the Edit and Audit RI Medicaid Claim are at

[135] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

Level 2. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.

The table below summarizes the capability improvements for the Edit and Audit RI Medicaid Claim business process over the next 5 years.

10-Year View

With use of standard interfaces and almost full automation, this business process will be at a level 3 capability within 10 years.

The Edit and Audit Medicaid Claim business process will be standardized and integrated. The process will be completely automated with only rare occasions of paper submission. Standardized data, web portals and edit and audit rules will be the main features of the process. Claim submission will be fully automated using national standards (HIPAA) and optimized for real-time processing, which will further improve error rates and timeliness.

The table below summarizes the capability improvements for the Edit and Audit RI Medicaid Claim business process that are targeted 5-10 years from now.

Table 34: Future Maturity Level by MITA Quality: Edit and Audit RI Medicaid Claim

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Most providers will submit HIPAA compliant transactions. The process will continue to be expensive and time-consuming.**	**2**	**Use of standard interfaces and nearly full automation, as well as payer-to-payer COB flags for third party claims.**	**3**
Timeliness	Electronic claim processing and POS adjudication greatly increase timeliness. (No change from Current View)	2	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	3
Data Access & Accuracy	Most providers submit claims via Web portals, email, dial-up, POS, and EDI. Electronic transactions will meet HIPAA data standards. (No change from Current View)	2	The majority of transactions will be submitted electronically Electronic transactions will meet nationally standard interfaces	3
Effort to Perform	If a claim/encounter data set fails edit validation, the process can now generate an electronic request for corrections via an X12 277. (No change from Current View)	2	Standardized data and edit rules will enable tracking of overutilization Edit processing will be highly flexible so that edit rules and code set changes can be made quickly	3
Cost Effectiveness	All claims for members with known third party resources are flagged for payer-to-payer COB, reducing provider burden and improving the timeliness of reimbursement. (No change from Current View)	3	All claims for members with known third party resources are flagged for payer-to-payer COB, reducing provider burden and improving the timeliness of reimbursement. (No change from Current View)	3
Accuracy of Process	Despite progress, related processes will continue to be tightly integrated, so that changes to edits can result in unintended downstream processing consequences. (No change from Current View)	2	The Edit Claim/Encounter process will be completely automated with only rare edit exceptions that must be manually reviewed.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	More small providers can submit electronically. (No change from Current View)	2	Agency staff are free to focus on strategic perspectives because operations are automated and accurate.	3

8.5 Edit and Audit RI Medicaid Encounter

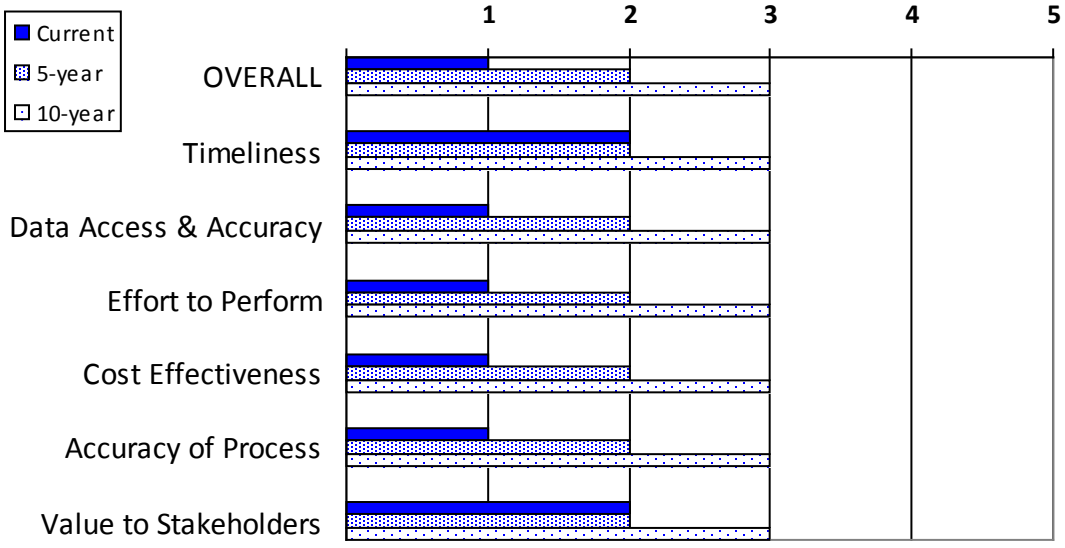
8.5.1 MITA Business Process Model

- Operations Management: OM2 Edit and Audit Claim/Encounter

8.5.2 Future Capability Overview

As shown in the figure below, all aspects of the Edit and Audit RI Medicaid Encounter business process will be at a capability level 2 in 5 years, with increasing migration toward more standardized encounter submissions. Within 10 years, all aspects of this process will be at a level 3, with integration of data submissions, standardization of formats and interfaces, and flexible business rules. Most qualities for this business process currently are at a level 1.

Figure 35: Current and Future Maturity Levels by Quality: Edit and Audit RI Medicaid Encounter



8.5.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Edit and Audit RI Medicaid Encounter business process:

Strategic Planning Influences

- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create mechanisms that support the Department's goal of rewarding improved plan performance.[136]
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser. More enrollees in Managed Care will increase the volume of encounters and facilitate the need for cleaner, more accurate data.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[137]
- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health

[136] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[137] ibid

information required for the payment of claims as well as determination of eligibility.[138]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.
- The method by which the Fiscal Agent receives encounter data is currently non-standard. There is data accuracy, integrity and timeliness issues with the current encounter data that impede the ability for the Department to utilize the encounter data for program management activities.
- A variety of incentives exist for health plans to submit timely and accurate encounter data. An encounter data component in the health plan capitation calculation provides health plans with an incentive to submit accurate, timely, and a consistent volume of data.

8.5.4 Expected Characteristics

5-Year View

With increasing integration of siloed programs, improved standardization, and somewhat more flexible business rules, the Edit and Audit RI Medicaid Encounter business process will be at a capability level 2 within 5 years.

The Edit and Audit RI Medicaid Encounter business process will be increasingly automated, and data quality from the plans will improve. Encounters will continue to be submitted electronically by health plans, but the format may not be completely

[138] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

standardized in 5 years. For example, NPI will become the standard provider enumerator for both Managed Care and fee-for-service, which will help improve individual provider performance monitoring across programs.

These improvements in standardization and data quality will result in increasing use of the Medicaid encounter data. Examples include improved managed care plan performance and support of updated managed care plan rate-setting methods.

This Medicaid business process is not expected to be at Level 3 within 5 years. Significant improvements to this process are not expected until after enhancements to the existing-MMIS are made, which is targeted for the later half of this 5-year view.

The table below summarizes the capability improvements for the Edit and Audit RI Medicaid Encounter business process that are targeted over the next 5 years.

10-Year View

Automation will be optimized, there will be more flexibility in updating business rules, and data formats will be standardized to support a level 3 capability for this business process within 10 years.

The Edit and Audit RI Medicaid Encounter business process will use standardized data and interfaces which will improve accuracy, reduce cost, and increase efficiency. Edit processing will be highly flexible so that edit rules and code set changes can be made quickly and inexpensively, making it more efficient to process encounters. With the increase in automation, staff will be free to focus on other strategic objectives, such as assessing plan performance and learning more about health care disparities between plans and populations. Health Plans will begin to align as part of a larger effort to share Health Information Exchange (HIE) best practices.

The table below summarizes the capability improvements for the Edit and Audit Medicaid Encounter business process that are targeted 5-10 years from now.

Table 35: Future Maturity Level by MITA Quality: Edit and Audit RI Medicaid Encounter

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Despite improved standardization and somewhat more flexible business rules, maintenance will continue to be expensive and time-consuming**	**2**	**Integration of siloed programs, standardization of data and interfaces, and flexible business rules**	**3**
Timeliness	Electronic claim processing and POS adjudication greatly increases timeliness. (No change from the current view).	2	Turnaround time can be immediate.	3
Data Access & Accuracy	Encounter data will be received electronically or posted to Web sites and use state specified, non-HIPAA-compliant formats.	2	Edit and Audit Encounter business process will use standard data and interfaces.	3
Effort to Perform	Process will generate a standardized electronic inquiry or correction request.	2	All siloed payment systems will be integrated Edit processing will be highly flexible so that edit rules and code set changes can be made quickly and inexpensively.	3
Cost Effectiveness	Maintenance will continue to be expensive and time-consuming.	2	Due to increased efficiency, staff can be redirected to more productive tasks.	3
Accuracy of Process	Despite progress, related processes continue to be tightly integrated so changes to edits can result in unintended downstream consequences.	2	Optimizing automation will improve error rates and timeliness, thereby enabling support of real-time claims/encounter processing.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	Increases in number of small providers who can submit electronically. (No change from the current view)	2	Agency staff will be free to focus on strategic perspectives because operations are automated and accurate.	3

8.6 Inquire RI Medicaid Payment Status

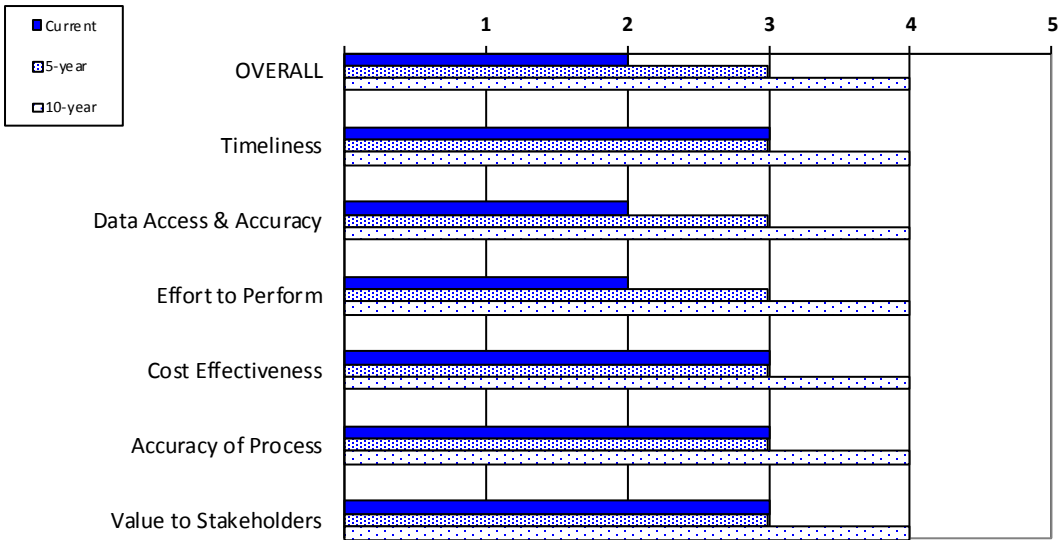
8.6.1 MITA Business Process Model

- Operations Management: OM5 Inquire Payment Status

8.6.2 Future Capability Overview

As shown in the figure below, all aspects of the Inquire RI Medicaid Payment Status business process will be at a level 3 in 5 years. Within 10 years, all aspects of this process will be at a level 4, with all programs using a common, automated claim status inquiry process. At that time, the process will feature flexible business rules and harmonization across all programs that pay Medicaid claims, leveraging and adapting sharable Medicaid claims processing services to further align currently divergent processes. Most qualities for this business process currently are at a level 3.

Figure 36: Current and Future Maturity Levels by Quality: Inquire RI Medicaid Payment Status



8.6.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Inquire RI Medicaid Payment Status business process:

Strategic Planning Influences

- HIPAA initiative to migrate health care industry from version 004010A1 to version 005010A1/A2 and from NCPDP 5.1 to D.0 and the new subrogation transaction NCPDP 3.0.
- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[139]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[140]

[139] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[140] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.[141]

8.6.4 Expected Characteristics

5-Year View

With agency data standards and automatic updates, all qualities of the Inquire RI Medicaid Payment Status business process will be at a capability level 3 within 5 years.

All programs will use a centralized automated electronic claim status process. Updates are distributed to data sharing partners and update notifications are sent to federated registries.

The table below summarizes the capability improvements for the Inquire RI Medicaid Payment Status business process that are targeted over the next 5 years.

10-Year View

With real-time claim adjudication, claim payment status is provided immediately. This supports a level 4 capability for this business process within 10 years.

All Medicaid Payment Inquiry functions will be standardized and integrated. Although the Medicaid processes may be supported by different systems with different business rules, they will share common standards with the Medicaid process.

At Level 4, claims processing will be replaced by direct communication between the provider's clinical data system and the payer system. Data will trigger registry updates and push data to other applications (eg, EHRs, registries). The providers' systems will alert the provider to any clinical protocols and to any business rules required by the agency in order for the service to be paid.

[141] Ibid, Slide 6

The table below summarizes the capability improvements for the Inquire RI Medicaid Payment Status business process that are targeted 5-10 years from now.

Table 36: Future Maturity Level by MITA Quality: Inquire RI Medicaid Payment Status

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**All programs use a centralized automated electronic claim status process based on MITA standard interface.**	**3**	**Claim adjudication will be immediate and providers will receive payment status immediately.**	**4**
Timeliness	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness. (No Change from the Current View).	3	Adjudication results are known immediately, eliminating the need for claim status inquiries.	4
Data Access & Accuracy	Interfaces use MITA standards. Providers send HIPAA X12 276 or use online direct data entry and receive HIPAA X12 277 response or find the claim status online.	3	At Level 4, claims processing will be replaced by direct communication between the provider's clinical data system and the payer system.	4
Effort to Perform	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	3	Data will trigger registry updates and push data to other applications (eg, EHRs, registries)	4
Cost Effectiveness	Further reduction of staff required to perform business process. (No Change from the Current View).	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care management; stakeholder satisfaction.	4
Accuracy of Process	Rules are consistently applied. Decisions are uniform. (No Change from the Current View).	3	Use of clinical data will improve consistency of results.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency. (No Change from the Current View).	3	The providers' systems will alert the provider to any clinical protocols and to any business rules required by the agency in order for the service to be paid.	4

8.7 Price RI Medicaid Claim

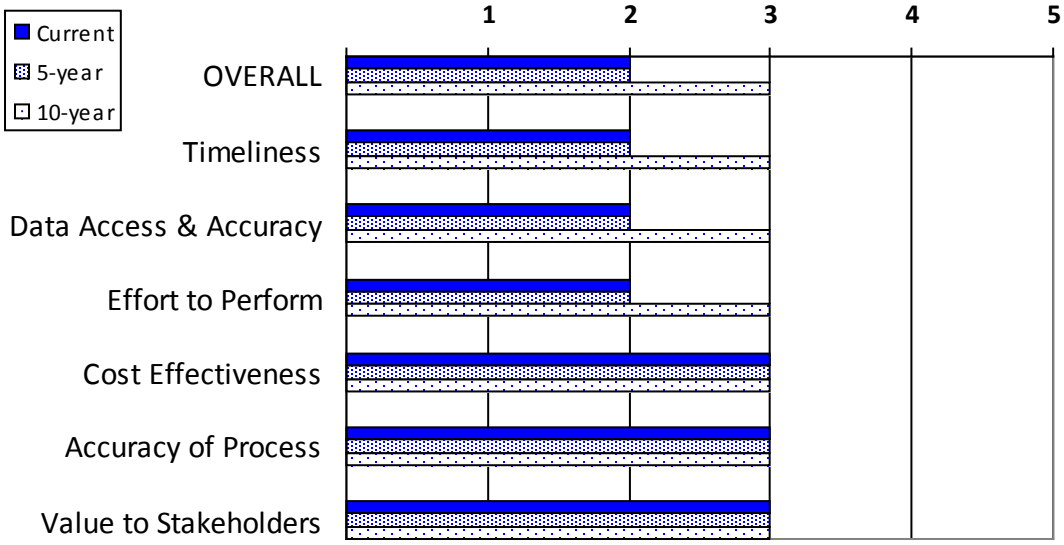
8.7.1 MITA Business Process Model

- Operations Management: OM2 Price Claim/Value Encounter

8.7.2 Future Capability Overview

As shown in the figure below, most aspects of the Price RI Medicaid Claim business process will remain at a capability level 2 in 5 years, with more automated pricing and fewer exceptions that require manual intervention. Within 10 years, all aspects of this process will be at a level 3, with use of standard interfaces and flexible business rules to price Medicaid claims. Most qualities for this business process currently are at a level 2.

Figure 37: Current and Future Maturity Levels by Quality: Price RI Medicaid Claim



8.7.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Price RI Medicaid Claim:

Strategic Planning Influences

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[142]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

8.7.4 Expected Characteristics

5-Year View

The Price RI Medicaid Claim business process will remain at a capability level 2 within 5 years.

This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for most qualities of the Price RI Medicaid Claim are at Level 2.

[142] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.

The table below summarizes the capability improvements for the Price RI Medicaid Claim business process over the next 5 years.

10-Year View

Use of standard interfaces and flexible business rules to price Medicaid claims will support a level 3 capability for this business process within 10 years.

Flexible business rules will allow maximum flexibility in changing pricing algorithms. Pricing turnaround time can be immediate with updates that will be distributed to federated claims registries. Due to increased efficiency, staff can be redirected to more productive tasks.

Interdepartmental collaboration will allow Medicaid programs to leverage MMIS improvements across the various claim types. Although the process for other programs may be supported by different systems with different business rules, they will share common standards. Other departments will benefit from sharing of the Medicaid service for this business process.

The table below summarizes the capability improvements for the Price RI Medicaid Claim business process that are targeted 5-10 years from now.

Table 37: Future Maturity Level by MITA Quality: Price RI Medicaid Claim

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Pricing will be more automated with fewer exceptions that require manual pricing. (No change from the Current View)**	**2**	**Flexible business rules and standard interfaces will be used to price claims and can be done immediately.**	**3**
Timeliness	Process time will be faster than level 1 because of Web portal, EDI, or other automated form. Timeliness will exceed legal requirement. (No change from the Current View)	2	Turnaround time can be immediate	3
Data Access & Accuracy	More services will be automatically priced and there will be fewer "by-report" manual pricing exceptions. (No change from the Current View)	2	The agency will use standard interfaces to price claims	3
Effort to Perform	Most single claim adjustments will be automated. (No change from the Current View)	2	Updates will be distributed to data sharing partners. Distributed update notifications to federated registries.	3
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks (No change from the Current View)	3	Due to increased efficiency, staff can be redirected to more productive tasks (No change from the Current View)	3
Accuracy of Process	Flexible business rules will allow maximum flexibility in changing pricing algorithms (No change from the Current View)	3	Flexible business rules will allow maximum flexibility in changing pricing algorithms (No change from the Current View)	3

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	Agencies will benefit from sharing of the business service and information with other agencies (No change from the Current View)	3	Agencies will benefit from sharing of the business service and information with other agencies (No change from the Current View)	3

8.8 Prepare Recipient Explanation of Member Benefits

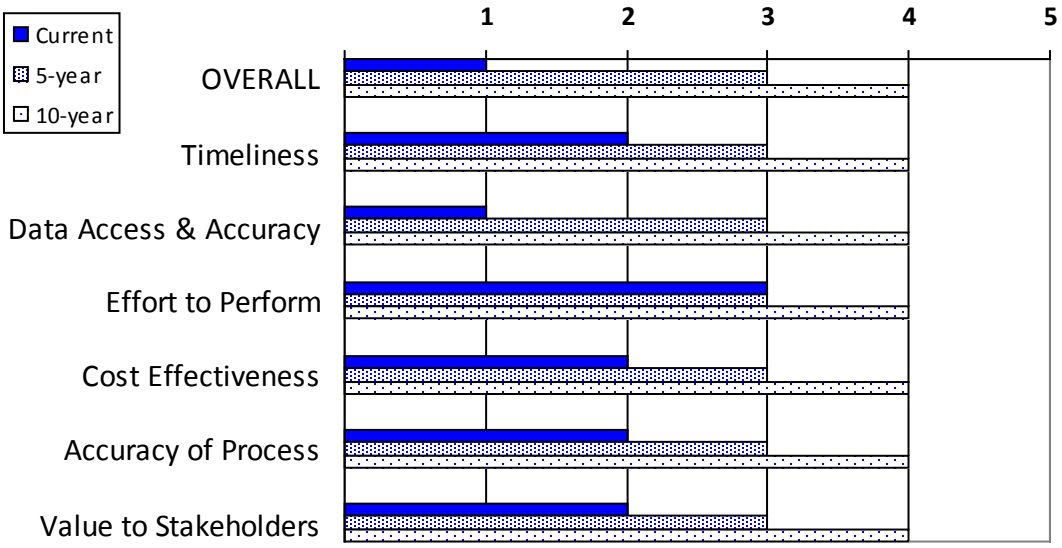
8.8.1 MITA Business Process Model

- Operations Management: OM3 Prepare EOB

8.8.2 Future Capability Overview

As shown in the figure below, all aspects of the Prepare Recipient Explanation of Member Benefits business process will be at a capability level 3 in 5 years, with standard interfaces and collaboration with other departments. Within 10 years, process time will be immediate using real time clinical data. Most qualities for this business process currently are at a level 2.

Figure 38: Current and Future Maturity Levels by Quality: Prepare Recipient Explanation of Member Benefits



8.8.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Medicaid Fraud Control Unit's (MFCU) priorities related to reaching the 5- and 10-year capabilities for the Prepare Recipient Explanation of Member Benefits business process:

Strategic Planning Influences

- A goal of the Global Waiver is to promote accountability and transparency.
- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[143]
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.[144]

[143] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[144] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

8.8.4 Expected Characteristics

5-Year View

With standard interfaces and collaboration with other departments in data-sharing, the Prepare Recipient Explanation of Member Benefits business process will be at a capability level 3 within 5 years.

Algorithms for determining REOMB targets will be applied more consistently in the claims processing system to assist with case-building. DCYF, BHDDH, and DEA will collaborate with DHS in the REOMB process (e.g., including aggregated interdepartmental data on the Medicaid beneficiary). Results of the REOMB replies will increasingly involve standardized electronic data exchanges within the Department and its partners, including its federated case registries.

As the various internal case tracking and detection systems converge, the department will receive more timely and reliable information about trends and actions related to REOMBs. Performance metrics will be readily available in the MFCU's case tracking system, including costs expended per beneficiary contact, e.g., new cases or recoveries per 1,000 REOMBs.

The table below summarizes the capability improvements for the Prepare Recipient Explanation of Member Benefits business process that are targeted over the next 5 years.

10-Year View

Immediate processing using real-time clinical data will support a level 4 capability for this business process within 10 years.

With an increasing focus on care management and with a decreasing priority on the REOMB tools, the Personal Health Record will become the means by which patients and care managers will validate the services delivered in real-time. Also as more cost-effective program integrity practices emerge, the Recipient Explanation of Member Benefits business process will continue to decline in priority as a fraud detection and prevention tool.

The MFCU will overcome data exchange obstacles and improve their sharing of patient and provider information. Real-time updates to federated registries will be triggered automatically. There will be increased collaboration within the MFCU and among other departments in case tracking, case management and investigative work. Decreased reliance on the REOMB process may result in its elimination.

Due to increased automation and greater use of clinical data, staff can be refocused increasingly on performance outcomes and quality assurance. Additional specialized medical positions (e.g., dentists) may be established in MFCU to take advantage of the increased availability of clinical data.

The table below summarizes the capability improvements for the Prepare Recipient Explanation of Member Benefits business process that are targeted 5-10 years from now.

Table 38: Future Maturity Level by MITA Quality: Prepare Recipient Explanation of Member Benefits

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Standard interfaces will be used for EOBs and collaboration will occur between agencies sharing the process.**	**3**	**Process will be immediate using real time, clinical data.**	**4**
Timeliness	Turnaround time can be immediate.	3	Process time will be immediate. Clinical data will be available in real time.	4
Data Access & Accuracy	Other agencies will collaborate with Medicaid in the EOMB process.	3	EOMB will be replaced by a Personal Health Record.	4
Effort to Perform	All EOBs will be coordinated among data sharing partner agencies in the state. (No change from the Current View)	3	Business processes will be transformed and efficiency is optimized through integration of clinical data.	4
Cost Effectiveness	Agencies will adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally.	3	Integration of clinical data will stimulate a quantum leap in cost-effective results.	4
Accuracy of Process	Optimizing automation will improve error rates and timeliness of this process.	3	Real-time access to source data will ensure accuracy and improve process performance.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	Level 3 will focus on building Member, Provider, and Medicaid Operations business services.	3	Use of clinical data will improve most major business processes. Member and Provider stakeholders will be empowered to participate in decision making.	4

8.9 Prepare RI Medicaid Provider / Premium EFT:

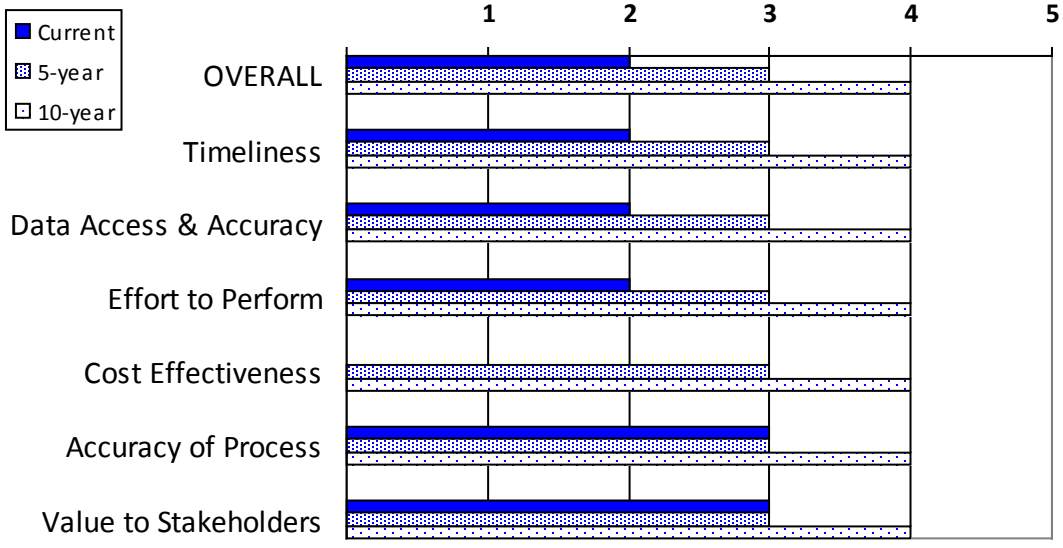
8.9.1 MITA Business Process Model

- Operations Management: OM3 Prepare Provider EFT / Check
- Operations Management: OM3 Prepare Premium EFT / Check

8.9.2 Future Capability Overview

As shown in the figure below, all aspects of the Prepare RI Medicaid Provider/Premium EFT business process will be at a capability level 3 in 5 years, where the process demonstrates improved Return on Investment projected by the Medicaid Enterprise and is more cost effective. Within 10 years, all aspects of this process will be at a level 4 where payments are made directly to provider bank accounts triggered by entries into clinical records maintained by the provider. Most qualities for this business process currently are at a level 2.

Figure 39: Current and Future Maturity Levels by Quality: Prepare RI Medicaid Provider / Premium EFT



8.9.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Prepare RI Medicaid Provider/Premium EFT business process:

Strategic Planning Influences

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[145]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

8.9.4 Expected Characteristics

5-Year View

Immediate turnaround and automatic verification will support a level 3 capability for this business process within 5 years.

Departments will adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and

[145] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

regionally. This collaboration will allow Medicaid programs to leverage MMIS improvements across the various claim types. Although the process for other programs may be supported by different systems with different business rules, they will share common standards. Other departments will benefit from sharing of the Medicaid service for this business process.

The table below summarizes the capability improvements for the Prepare RI Medicaid Provider/Premium EFT business process that are targeted over the next 5 years.

10-Year View

Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction, and will support a level 4 capability for this business process in 5 to 10 years.

Payments will be made directly to provider bank accounts triggered by entries into clinical records maintained by the provider and accessed by the program. Premium payments will be made directly to MCO, insurance company, Medicare buy-in, et al bank accounts based on enrollment information. Internal and regional person/patient registries and other enrollment data sources can be auto/ad hoc queried for changes in verification or enrollment status.

The table below summarizes the capability improvements for the Prepare RI Medicaid Provider/Premium EFT business process that are targeted within 5 to 10 years.

Table 39: Future Maturity Level by MITA Quality: Prepare RI Medicaid Provider / Premium EFT

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.**	**3**	**Process time is immediate. Clinical data is available in real time.**	**4**
Timeliness	Turnaround time can be immediate.	3	Process time is immediate.	4
Data Access & Accuracy	Through inter-agency coordination, multiple agencies share the same EFT process.	3	Payments are made directly to provider bank accounts triggered by entries into clinical records maintained by the provider and accessed by the payer.	4
Effort to Perform	Verification is fully automated and immediate. Automated verification and application response are real time.	3	Internal and regional person/patient registries and other enrollment data sources can be auto/ad hoc queried for changes in verification or enrollment status.	4
Cost Effectiveness	Agencies adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally all of which improve cost-effectiveness.	3	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.	4
Accuracy of Process	The agency has the flexibility to easily change the business rules. (No change from the Current View)	3	Self adjusting business rules.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Value to Stakeholders	Agencies benefit from sharing of the business service and information with other agencies. (No change from the Current View)	3	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	4

8.10 Prepare RI Medicaid Remittance Advice

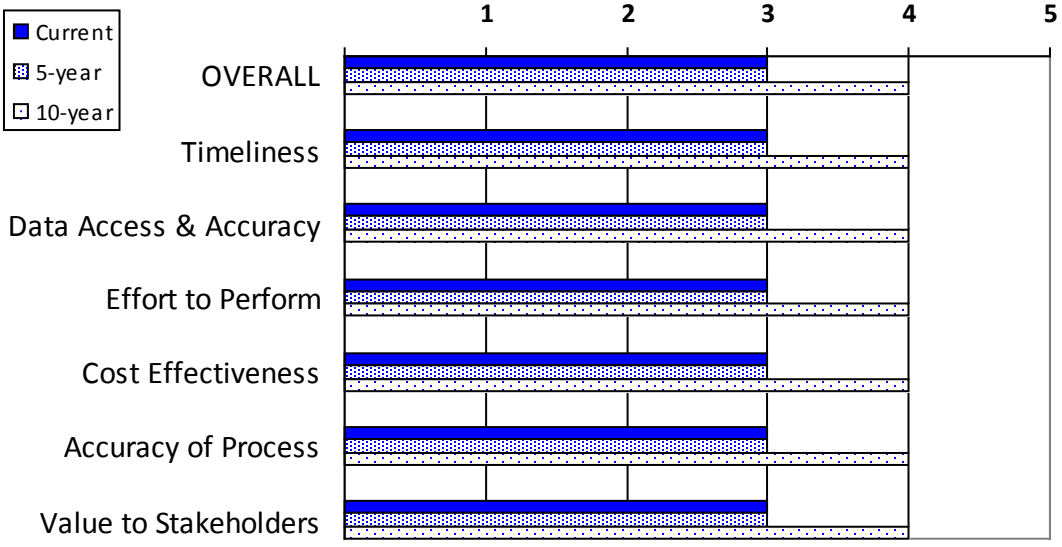
8.10.1 MITA Business Process Model

- Operations Management: OM3 Prepare Remittance Advice/Encounter Report

8.10.2 Future Capability Overview

As shown in the figure below, all aspects of the Prepare RI Medicaid Remittance Advice business process will remain unchanged for the next 5 years, with no major initiatives currently underway that are expected to significantly impact the maturity of this process. Within 10 years, all aspects of this process will be at a level 4, with introduction of real-time processing and readily available Medicaid beneficiary data via electronic health records. All applicable qualities for this business process currently are at a level 3.

Figure 40: Current and Future Maturity Levels by Quality: Prepare RI Medicaid Remittance Advice



8.10.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the Prepare RI Medicaid Remittance Advice business process:

Strategic Planning Influences

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.[146]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

8.10.4 Expected Characteristics

5-Year View

The Prepare RI Remittance Advice business process will remain at a capability level 3 within 5 years. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.

[146] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

The table below summarizes the capability improvements for the Prepare RI Remittance Advice business process over the next 5 years.

10-Year View

With the introduction of real-time processing and readily available Medicaid beneficiary data via electronic health records, the Prepare RI Medicaid Remittance Advice business process will be at a capability level 4 within 10 years.

Payments will be made directly to provider bank accounts triggered by entries into clinical records maintained by the provider and accessed by the program.

The table below summarizes the capability improvements for the Prepare RI Medicaid Remittance Advice business process that are targeted 5-10 years from now.

Table 40: Future Maturity Level by MITA Quality: Prepare RI Medicaid Remittance Advice

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Process will nearly eliminate paper RAs and will use standard interfaces. (No change from the Current View)**	**3**	**Process will be immediate using real-time clinical data in a provider to payer system communication.**	**4**
Timeliness	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness. (No change from the Current View)	3	Process time will be immediate. Clinical data will be available in real time.	4
Data Access & Accuracy	Process will use standard interfaces for the RA. Paper RAs are still supported on an exception basis. (No change from the Current View)	3	With provider clinical system to payer system communication, the RA will be replaced by a new accounting mechanism.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Effort to Perform	Verification will be fully automated and immediate. Automated verification and application response will be real time. (No change from the Current View)	3	Data will trigger registry updates and push data to other applications.	4
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks. (No change from the Current View)	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction.	4
Accuracy of Process	Rules will be consistently applied. (No change from the Current View)	3	Self adjusting business rules.	4
Value to Stakeholders	Agencies will benefit from sharing of the business service and information with other agencies. (No change from the Current View)	3	Providers, members, and care managers will access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	4

9.0 OPERATIONS MANAGEMENT: PREMIUM PAYMENTS

9.1 Prepare Capitation Premium Payment

9.1.1 MITA Business Process Model

- Operations Management: OM4 Prepare Capitation Premium Payment

9.1.2 Future Capability Overview

Within 5 years, all aspects of this process will be incorporated into the Prepare Premium Payment in the Operations Management business area. Similar to the process for preparing the RIte Share Premium Payment, preparing the Capitation Premium Payment begins with retrieving enrollment and benefit transaction data and formatting the payment data into the required data set.

9.2 Prepare Rite Care Member Premium Invoice

9.2.1 MITA Business Process Model

- Operations Management: OM6 Prepare Member Premium Invoice

9.2.2 Future Capability Overview

Within 5 years, all aspects of this process will be incorporated into the Prepare Remittance Advice in the Operations Management business area. Similar to the process for preparing the Remittance Advice, preparing the RIte Care Member Premium Invoice begins with receipt of data sets resulting from retrieving data, performing required data manipulation according to business rules, and formatting the results into required output dataset.

9.3 Prepare Medicare Premium Payment

9.3.1 MITA Business Process Model

- Operations Management: OM4 Prepare Medicare Premium Payment

9.3.2 Future Capability Overview

Within 5 years, all aspects of this process will be incorporated into the Prepare Premium Payment in the Operations Management business area. Similar to the process for preparing the RIte Share Premium Payment, preparing the Medicare Premium Payment begins with retrieving enrollment and benefit transaction data and formatting the payment data into the required data set.

9.4 Prepare Premium Payment

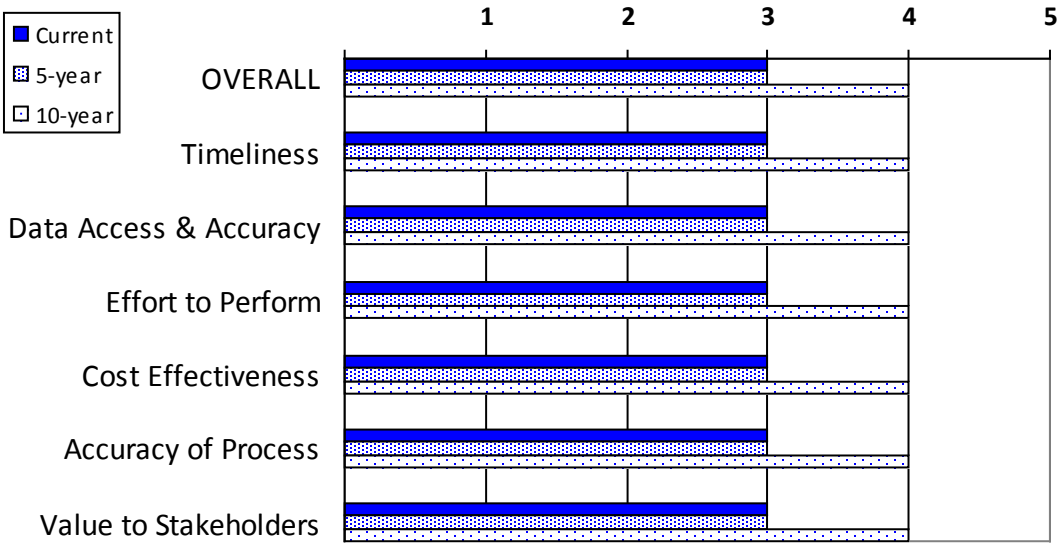
9.4.1 MITA Business Process Model

- Operations Management: OM4 Prepare Health Insurance Premium Payment
- Operations Management: OM4 Prepare Medicare Premium Payment
- Operations Management: OM4 Prepare Capitation Premium Payment

9.4.2 Future Capability Overview

Within the next 5 years, all separate premium payment proceses will conferge into a single process. Capitation, Medicare and RIte Share premium payment processes will follow the standard Prepare Premium Payment business process. All aspects of the Prepare Premium Payment will remain at a capability level 3 in 5 years. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years. Within 10 years, all aspects of this process will be at a level 4, with immediate processing using real-time clinical data to support Premium Payment decisions and premium EFT to insurers. All qualities for this business process currently are at a level 3.

Figure 41: Current and Future Maturity Levels by Quality: Prepare Premium Payment



9.4.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Claims Unit's priorities related to reaching the 5- and 10-year capabilities for the standard Prepare Premium Payment business process:

Strategic Planning Influences

- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in RIte Share/RIte Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).[147]
- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health

[147] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

information required for the payment of claims as well as determination of eligibility.[148]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[149]

9.4.4 Expected Characteristics

5-Year View

One of the enhancement requirements to the existing MMIS is to bring the manual process of preparing the Medicare Premium Payments into the standard processing of premium payments within the MMIS. All premium payments, including capitation, Medicare and RIte Share, will be merged into a standard process for all premium payments (formally Prepare RIte Share Premium Payment). The Prepare Premium Payment business process will remain at a capability level 3 within 5 years.

There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.

The table below summarizes the capability improvements for the Prepare Premium Payment business process that are targeted over the next 5 years.

[148] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[149] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

10-Year View

Immediate processing of real-time clinical data to pay insurers directly into their bank accounts via RHIO registries will support a level 4 capability for this business process within 10 years.

Regional beneficiary registries and other enrollment data sources will be accessed to verify or update health insurance enrollment status. Self adjusting business rules, full automation of the process and access to clinical data will refocus staff on performance outcomes, care/disease management and stakeholder satisfaction.

The table below summarizes the capability improvements for the Prepare Premium Payment business process that are targeted 5-10 years from now.

Table 41: Future Maturity Level by MITA Quality: Prepare Premium Payment

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**The process will use standard interfaces to automatically verify beneficiary insurance coverage.**	**3**	**The process will use real-time clinical data to identify cases. RI Medicaid will submit premium EFTs directly to other insurers' bank accounts.**	**4**
Timeliness	Turnaround time can be immediate.	3	HIPP processing time will be immediate. Clinical data will be available in real time.	4
Data Access & Accuracy	The agency will use standard interfaces for identification of candidates for other payer buy-in, analysis of cost/ effectiveness, and health insurance premium payments.	3	Payments will be made directly to other insurer bank accounts via RHIO registries.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Effort to Perform	Verification will be fully automated and immediate. Automated verification and application response will be real time.	3	Internal and regional person / patient registries and other enrollment data sources can be queried for changes in verification or enrollment status.	4
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction	4
Accuracy of Process	The agency will have the flexibility to easily change the criteria for identification of members eligible for other insurance buy-in.	3	Self adjusting business rules will optimize the means be which HIPP candidates are identified and payment are managed.	4
Value to Stakeholders	Agencies will benefit from sharing the business service and information with other agencies.	3	Providers, members, and care managers will access standardized Member Registries to view clinical data needed for EHRs, PHRs, care management and premium payment.	4

10.0 PROGRAM INTEGRITY MANAGEMENT

10.1 Identify RI Medicaid Candidate Case

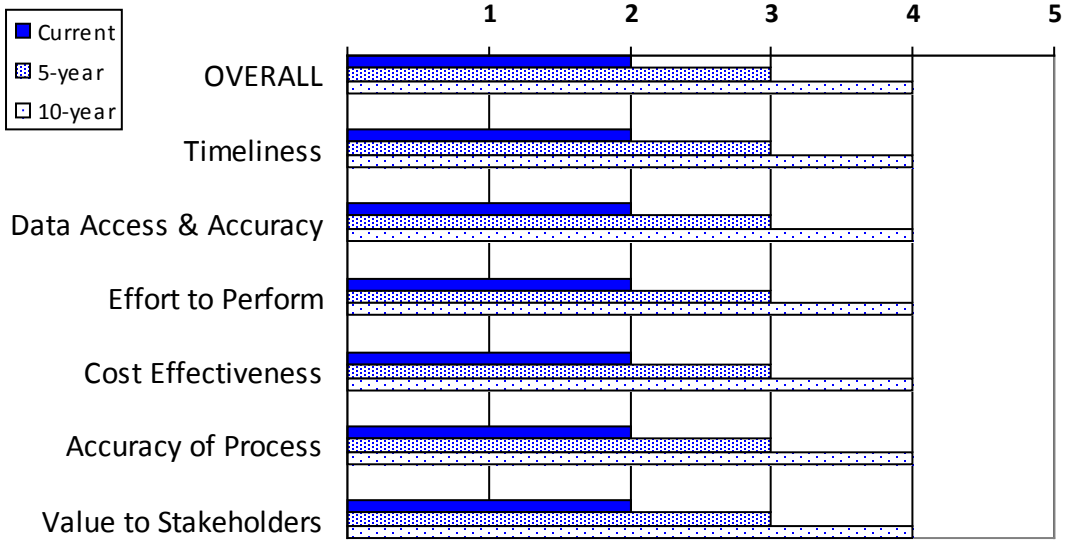
10.1.1 MITA Business Process Model

- Program Integrity Management: PI Identify Candidate Case

10.1.2 Future Capability Overview

As shown in the figure below, all aspects of the Identify RI Medicaid Candidate Case business process will be at a capability level 3 in 5 years, with improved automation and standardization in the way fraud is detected and cases are opened. Within 10 years, all aspects of this process will be at a level 4, with real-time clinical data leveraged through the Department's increasingly federated systems architecture and leads provided immediately to Program Integrity investigators. All qualities for this business process currently are at a level 2.

Figure 42: Current and Future Maturity Levels by Quality: Identify RI Medicaid Candidate Case



10.1.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the Program Integrity Section's priorities related to reaching the 5- and 10-year capabilities for the Identify RI Medicaid Candidate Case business process:

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.[150]
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims.[151]
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create mechanisms that support the Department's goal of rewarding improved plan performance.
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser. More enrollees in Managed Care will increase the volume of encounters and facilitate the need for cleaner, more accurate data.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global

[150] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[151] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[152]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase volume of Medicaid recipients to be managed.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity.[153]
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.[154]
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.

[152] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[153] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5
[154] ibid

10.1.4 Expected Characteristics

5-Year View

With increased standardization and almost complete automation, the Identify RI Medicaid Candidate Case business process will be at a capability level 3 within 5 years.

Although greater use of automated EHRs comes with the potential of an increase in the volume of inaccurate claims, access to clinical data will help with identification and investigation of suspect claims activity. Anti-fraud algorithms will be applied more consistently in the claims processing system to detect potential suspects and to avoid questionable claims prospectively. Results of these and other case-finding methods will rely increasingly on standardized electronic data exchanges within the Agency and its partners, including federated case registries.

As the various internal case tracking and detection systems converge, Program Integrity Section's customers will receive more timely and reliable information about whether a specific provider or beneficiary has an existing case. Performance metrics will be readily available in the Section's case tracking system, including hours and costs expended per new case. In addition to increasing electronic data entry and interchange within the Program Integrity case tracking tools, paper documents will be scanned and linked electronically to further automate the audit file. Due to increased coordination and efficiencies, staff in Program Integrity Section (and in other business units that support anti-fraud efforts, e.g., MFCU) can be redirected to more labor intensive tasks, e.g., site visits and care management.

The table below summarizes the capability improvements for the Identify RI Medicaid Candidate Case business process that are targeted over the next 5 years.

10-Year View

Immediate processing using real-time clinical data and the Department's increasingly federated systems architecture will support a level 4 capability for this business process within 10 years.

Providers, members, and care managers will access standardized Member Registries and electronic health records to validate and view real-time clinical data. Member verification will include biometric authentication (e.g., a thumbprint scan).

Program Integrity Section's anti-fraud partners will overcome their data exchange obstacles and improve their sharing of case information. Real-time updates to federated case registries will be triggered automatically. There will be increased collaboration within the Department and among other agencies in identifying and collaborating on new cases.

Due to increased automation and greater use of clinical data, staff can be refocused increasingly on performance outcomes, care management, and quality assurance. Additional specialized medical positions (e.g., dentists) may be established in Program Integrity to take advantage of the increased availability of clinical data.

The table below summarizes the capability improvements for the Identify RI Medicaid Candidate Case business process that are targeted 5-10 years from now.

Table 42: Future Maturity Level by MITA Quality: Identify RI Medicaid Candidate Case

MITA Quality	5-Year View & Level		10-Year View & Level	
OVERALL	**Process will be standardized almost completely automated.**	**3**	**Process will be immediate using real-time clinical data and will interface with other processes via federated architectures.**	**4**
Timeliness	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	3	Process time will be immediate. Clinical data will be available in real time.	4

MITA Quality	5-Year View & Level		10-Year View & Level	
Data Access & Accuracy	Process will have almost eliminated its use of non-electronic interchange and has automated most processes.	3	Process will interface with other processes via federated architectures, including direct access to clinical data.	4
Effort to Perform	Updates will be distributed to data sharing partners. Distributed update notifications to federated registries.	3	Data will trigger registry updates and pushes data to other applications (e.g., EHRs, registries).	4
Cost Effectiveness	Due to increased efficiency, staff can be redirected to more productive tasks.	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction.	4
Accuracy of Process	Rules will be consistently applied. Decisions will be uniform.	3	Use of clinical data will improve consistency of results.	4
Value to Stakeholders	Stakeholders will experience seamless and efficient program communications no matter how or where they contact the Agency.	3	Providers, members, and care managers will access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	4